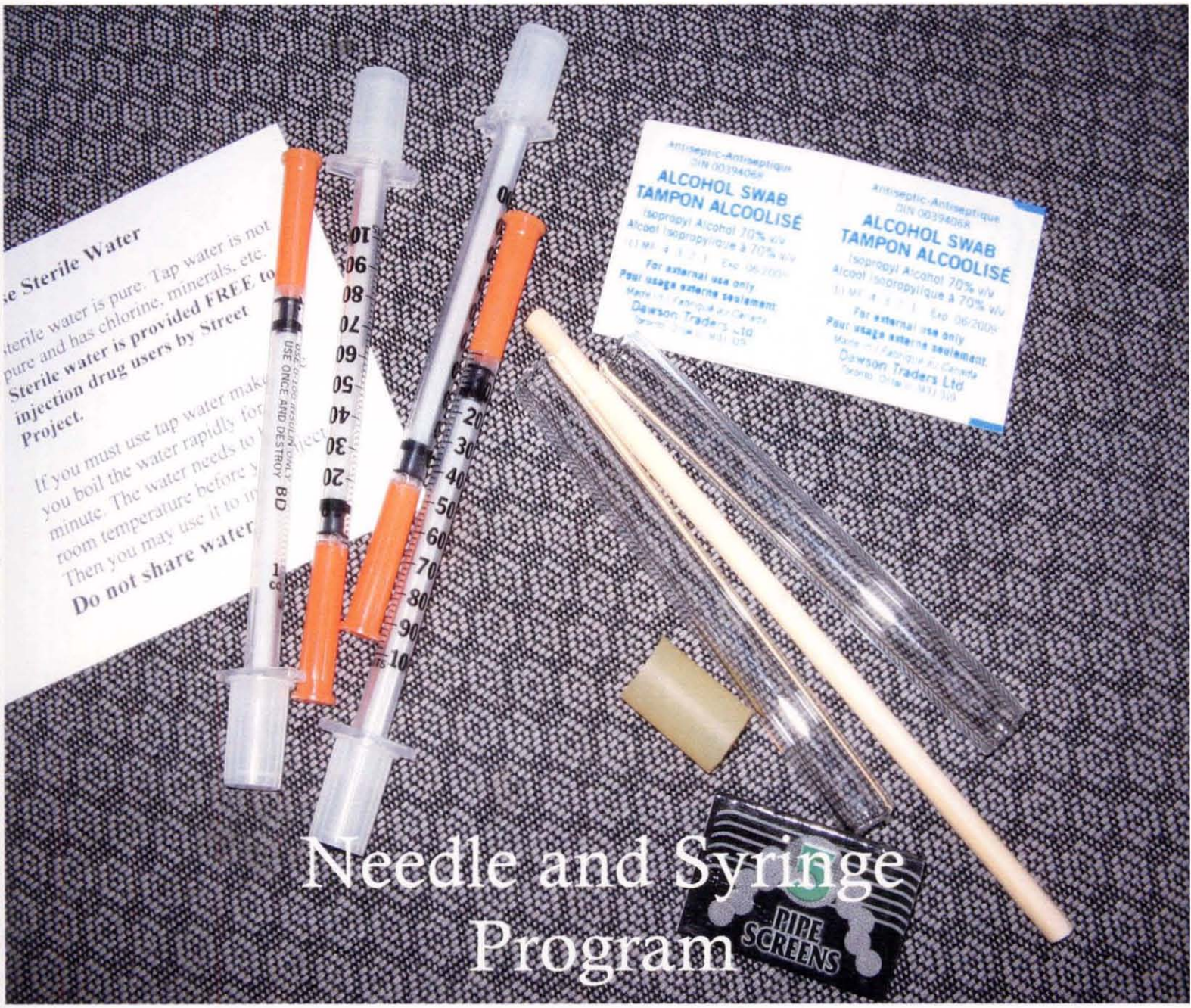
AIDS Program South Saskatchewan



A Community Approach

AIDS Programs South Saskatchewan

Needle and Syringe Program.
"A Community Approach"

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Foreword: What Truly Is an Effective Needle Syringe Program? Pointers to consider!

When we speak of Harm Reduction or indeed "best practices" what do we really mean and what Harm Reduction approaches or best practices are more for the provider than they are for the population you are trying to reach?

In our work it is sometimes difficult to step back and evaluate how our evolved programs and practices have impacted the population we try to serve.

Because AIDS Programs South Saskatchewan is one of only a very few community based organizations doing needle distribution we are often in a position where our work may not be viewed to be as valuable as the work of the 'professionals" and on the other hand, also in the unique position of being able to evaluate what is out there as best practice and make changes swiftly to meet any changes in practice.

It must be noted that the "Best Practices" of Needle Exchange Programs (NEPs) has been an evolution. In the early days of NEPs the whole focus was to reduce the numbers of HIV infections among the injecting population by just getting clean needles/syringes out to them. That was it. No "program" in a specific sense, health providers simply responded to a spike in HIV infections that basically went straight up the chart (UK 1980s). Once the initial HIV epidemic subsided and the "programs" evolved, health providers were under less pressure to respond to crisis situations and then the "programming" came along.

The practice of exchange, getting new for old, registering clients and insisting that clients must engage in health sharing and information, to be provided the service are all still to this day seen as best practices. However, at an October 2006 conference held in London England the "users" presented that they are sharing again and that people are sharpening their "rigs" on matchbook covers.

This information did not seem to impede the beliefs of the health care providers that the way it is done now MUST be the way it is done! As we carry out our programs and provide to those we wish to make a difference for (or for the greater good of Public Health) we must be open to what the client needs and will respond positively to. This can be demonstrated in the numbers of clients and distribution numbers at AIDS Programs South Saskatchewan.

What works for some doesn't work for all and it is the goals of all providers to reduce infections and provide health services to those individuals who inject drugs. Our experience has shown that people interacting with APSS program staff build trust, have fun with and spend time to share with clients what's happening now and in some cases their life stories. This is key to successfully working with this population and we hope this document will assist those working in the field or those considering starting a NEP in their community. We intend that it will certainly enhance our NEP.

Chris Smith, Executive Director

AIDS Program South Saskatchewan
Needle and Syringe Program

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AIDS Program South Saskatchewan
Needle and Syringe Program

Background of APSS Needle and Syringe Program:

APSS has been providing a NEP for the last 7 years, prior to that APSS was purchasing and supplying the needles/syringes to Carmichael Outreach Services for two years. The First NEP originally started up in 1992 with the Street Project. The Street Project is part of the Regina Qu"Appelle Health Region (RQHR). Currently, APSS receives their supplies from the RQHR. These supplies include needles/syringes, alcohol swabs; sharp containers and also a supply of zip lock bags for the needles/syringes.

The program is simple: bring in your dirty needles/syringes and we'll replace them with new ones. However, if the individual doesn't return any used needles/syringes we will provide them with new needles depending on how many people are using them, with the encouragement of returning the used needles the next time they come in. We will never tell a client that using is bad or that they should just quit. Nor will they be judged or discriminated against because they choose to use injection drugs.

The focus is to teach them how to inject more safely without being judgmental, they decide for themselves when its time to get help, if they ever want any help. Once the individual makes that request we do start the process of referral into detox, treatment centers or counseling? If, along that road the client is more open to education on safer-injecting, or learning about HIV or Hepatitis "C", or perhaps going so far as to be tested, then we'll feel even more successful.

APSS Needle Exchange Program is a non-profit community based initiative that receives minimal funding to provide these services's, but through staff involvement, provides the exchange of used needles/syringes for clean sterile ones, sharp containers and alcohol swabs. However, APSS would like to eventually distribute all other drug paraphernalia such as, water, spoons, filters and tourniquet. APSS provides a variety of condoms to the clients and at present have partnerships with Addictions Services, RQHR for a nurse/counselor and Planned Parenthood Sexual Health Services for nurses to provide birth control and sexual/reproductive health services, both attend a half day a week on the afternoon. Such partnerships are a real strength to the program.

The clients coming through the doors are encouraged to take condoms; informational brochures' and view advertisements of community events posted at the front. Some clients have developed a rapport with the staff and are comfortable in asking specific questions regarding HIV, Hepatitis "C" and nutrition? What causes blood clots? How do I take care of abscesses and wounds? What will happen if the police search me and find the needles/syringes? What happens when you mix methadone with other drugs? These are questions that the staff will try to answer or provide the information to the clients.

Needle Exchange Programs/Needle & Syringe Programs

The Mission & Vision Statements

The mission of NEP/NSP is a universal concept to improve the health and reduce the harm to the people impacted by the use of drugs through support, intervention, education and disease prevention.

The vision is that our community will embrace and implement harm reduction based services that are easily accessible, non-judgmental and respectful to those affected by drug use.

- Injecting drug mis-users (IDMU), whether infected or not, are people with whom we will work with
- The project offers innovative harm reduction strategies for motivating drug mis-users to change high risk behaviors associated with drug use
- NEP/NSP reduces the risks of Blood Borne Pathogen transmission and does not increase the use of injected drugs

The central concept for the NEP/NSP was to help people without making judgments about their addictions or requiring them to stop using before receiving help. NEP/NSP is based on the philosophy of harm minimization, that is, to reduce the potential harm resulting in injecting drugs rather than attempting to curtail the activity itself. However, the primary function of a Needle Exchange Program (NEP) is to provide injection drug users with clean needles/syringes and other supplies necessary for safe injection of **illicit drug misuse**. Needle & Syringe Program (NSP) is very similar to the NEP; however, the main focus is to provide Injection Drug Mis-Users (IDMU) with clean and sterile needles/syringes without exchanging dirty, used ones, with the emphasis on informing clients to bring in any used needles/syringes the next time they come in.

The premise is that needle/syringe provisions reduces unsafe injection practices such as, needle sharing, curtails transmissions of Blood Bourne Virus' (BBV), such as, HIV, Hepatitis "B" and Hepatitis "C", increases safe disposal of used needles/syringes and helps injecting drug users obtain drug information, treatment, detoxification, social services and primary health care upon request. The benefit of the NEP is that millions of used needles/syringes have been disposed of safely, when otherwise they may have been discarded inappropriately in the community.

It is known that in many cases of BBV transmission result from unsafe injecting practices, such as sharing needles/syringes. NEP/NSP are designed to minimize the risky behaviors that contribute to BBV transmissions. NEP/NSP aim is to reduce

harm to the user and the wider community, by reducing the spread of BBV; NEP's are examples of an intervention that is guided by the principle of reducing harm.

There is overwhelming evidence that the NEP/NSP are effective to substantially reduce the infection of Blood Bourne Virus's and that it eliminates the re-use of needles/syringes. NEP/NSP are cost effective strategies for reducing HIV and Hepatitis "C" transmission. Accumulated evidence from Canada, USA and Australia shows that NEP/NSP are cost effective when compared with the lifetime cost of treating HIV infections. In Hamilton Ontario, the cost of operating an NEP over 5 years was compared with the life time cost of treating HIV/AIDS infections. The authors predict that the program would prevent 24 cases of HIV infection over 5 years, giving a cost saving of $1.3 million over 5 years. (Ontario Needle Exchange Programs: Best Practice Recommendations March 2006).

Despite continued compelling data making evident the effectiveness, efficacy and efficiencies of NEP/NSP, and are key players in public health, many of these programs currently survive with minimal and/or inadequate funding or no funding at all. **What is often overlooked is the interaction that takes place during the encounter of the "giver" and "receiver". It is this interaction that is the significant component of the NEP/NSP, especially when the encounters are repeated, trust and even friendship is established. The exchange comes to encompass more than a needle.**

Needle Exchange Program/ Needle and Syringe Program

Best Practice Recommendations – in detail

To prevent the transmission of HIV, HBV, HCV and other blood borne viruses (BBV) from injection with non-sterile needles/syringes:

- Provide sterile needles/syringes in the quantities requested by client:

    1. without requiring clients to return used needles/syringes
    2. with no limit on the number of needles provided with the encouragement to return used needles/syringes
    3. once a staff member becomes familiar with the clients, upon discretion of who returns the needles/syringes when they say they will or those who don't return used ones?

- Provide sharp containers and alcohol swabs to the clients
- Do not penalize clients who fail to return used needles/syringes

Injection with previously used needles put the IDMU at high risk for infection with blood borne viruses. Sharing is very common amongst IDMU. Used needles/syringes can serve as a reservoir and vector for transmission of HIV, HCV, HBV and other blood borne viruses. HIV can survive in used needles, but the survival times vary with the amount of blood residue and storage/handling of

the needle. Evidence of HCV has also been detected in used needles, and sharing needles is a major risk factor for HCV transmission in Canada.

HIV is the most fragile of the three viruses and survives a few hours after infected blood has dried on a surface. HCV is more easily transmitted through contaminated needles than HIV. However, the ability of the virus to survive on environmental surfaces is relatively poor.

HBV is more resilient than HIV and more infectious through blood contact. HBV is also a resilient and virulent virus. Viable virus can survive in dried blood at room temperature for at least a week. HBV is easily transmitted through needle sharing, however, transmission is a concern only for IDMU who have not been immunized or who have not developed immunity through previous exposure to the virus. (Ontario Needle Exchange Programs: Best Practice Recommendations, March 2006)

There are other concerns associated with any injection drug misuse. Any injection with a used needle, including one's own needle, puts the IDMU at risk for infections, and skin and vein damage. Injecting with a needle contaminated with bacteria and debris can lead to infections such as septicemia (blood poisoning) and endocarditis (inflammation in the arterial wall of the heart). Injection with a dull needle can cause trauma to the skin, veins and soft tissues and can lead to abscesses, cellulites (see attached appendix 1) and vein collapse.

A new, sterile needle should be used for every injection. Distribution of enough needles to facilitate the use of a sterile needle for each injection is the best method to eliminate the risk of transmitting BBV and bacterial infections from re-used or non-sterile needles to prevent vein damage from blunt or broken needles. NSP clients should be educated to understand:

- The importance of using a new sterile needle for each injection
- The risk of needle-sharing, including frontloading and back loading
- How to recognize and handle sterile needles
- How to inject safely (see safer injection education section)

Safer handling and disposal of used injection equipment

Best Practice Recommendations – in detail

- To prevent the transmission of HIV, HBV, HCV and other blood borne viruses (BBV), as well as bacterial infections from improperly discarded injection equipment.

    1. Educate staff and clients to safely handle and dispose of used injection equipment
    2. Do not penalize clients who fall to return used needles

3. Estimate the number of needles returned by clients. Neither staff or clients should count used needles by hand
4. Dispose of used needles and sharps container's in accordance with local regulations for biomedical waste
5. Encourage HBV vaccination for staff and clients

Handling used injection equipment: Recommendations for clients

1. Locate the sharps container close to area of use
2. Dispose of injection equipment immediately
3. Never re-cap a needle. This may lead to a needle stick injury, and (re)infection of HIV, HBC,HCV and other BBV
4. When exchanging needles for other people, ask them to deposit them in a sharps container first
5. Do not bend or break a needle

Handling used injection equipment: Recommendations for NSP Staff Personnel

1. Be aware that clients exchanging needles may be carrying needles on their person (e.g. in pockets, sleeves) or loose in a non-secure containers such as plastic or paper bags.
2. do not touch returned needles, clients must dispose their own needles, if a number of needles returned is required this can be done by eyeballing and/or asking clients how many needles they are returning.
3. When collecting used injection equipment discarded in the community always wear puncture resistant gloves or use the tong provided for needle pick-up.

The primary objective of safe handling and disposal of used injection equipment is to prevent injury and exposure to infected blood. The safe disposal of used needles (sharps) is an important strategy to reduce the amount of discarded needles in the community and the transmission of blood borne viruses BBV among IDMU, NSP staff personnel and the community. Removing the used needles from circulation helps reduce the risk of accidental needle stick injuries and the likelihood that the needles will be reused.

A needle stick injury is a wound caused when a needle accidentally punctures the skin. Needle stick injuries are a concern fro NSP staff personnel and clients who come into contact with used needles. The principal concerns are transmission of HIV, HBV, HCV and other BBV, as well as tetanus. Among healthcare workers, needle stick injuries are more common during procedures such as recapping a needle and disposing of equipment. However, when a needle is left exposed, a needle stick injury can occur. Recapping needles used by someone else poses a risk of needle stick injuries and transmission of BBV. Encouraging clients to dispose of used injection equipment in sharp containers can reduce the risk of injury.

Used equipment when discarded in the community poses a risk of injury to the general public. The risk of BBV from a needle discarded in the community is low, however, any needle stick injury may cause the injured person emotional stress and create opposition to the NSP. Challenges to safer disposal of used injection equipment include homeless and insecurely housed IDMU and those who have "hidden" drug use, having nowhere to store used equipment, and fear of police.

Sharps handling and disposal techniques

Clients should be encouraged to return used needles and sharp containers and should be aware of the risks associated to improperly discarded needles to the community at large. For example, used needles disposed in local and community garbage cans and toilets can pose risk of needle stick injuries to the sanitation workers and those individuals who rummage through garbage containers for bottles and cans for recycling purposes.

Needles should never be broken or bent. Sometimes needles are broken off from the barrel to prevent re-use; however, broken needles can carry BBV. They are also hard to see, can easily get lost, and pose the risk of needle stick injuries. If needle is broken off, encourage clients to dispose of all parts including barrel, plunger, points and any broken pieces. IDMU should never dispose of someone else's broken needles.

Providing clients with sharp containers can increase returns of used needles and decrease the chances of needle stick injuries or re-use. In addition, clients can be encouraged to dispose of needles immediately after use into the sharp containers that are placed as close to the location of use as possible. Neither clients nor staff should recap used needles or try to hand count the number of used needles that are returned. Hand counting greatly increases the risk of needle stick injuries. Estimating the number of returned needles is sufficient for program accounting and evaluation processes.

The APSS NSP staff personnel are called and sent out to pick up and dispose of the discarded needles. Regina Street Project, APSS, All Nation's Hope and their volunteers have adopted the pro-active initiative to do community clean-ups in the spring time. When collecting discarded needles in the community, it is suggested that puncture resistant gloves should be worn. Recommendations regarding the use of tongs are mixed. Concerns about the ability to control and hold the needle when using tongs has lead some agencies to discourage their use. However, others recommend the use of tongs to prevent needle stick injuries.

APSS Needle and Syringe Program

Goals:

To prevent the spread of Blood Bourne Virus' (BBV) such as, HIV, Hepatitis "B" and Hepatitis "C" by providing clean needles/syringes to injection drug mis-users (IDMU).

To provide individuals with an adequate amount of sterile needles/syringes, alcohol swabs, sharp containers and condoms that meet their requirements, with the intent in the future to distribute all other drug paraphernalia such as, water, spoons, filters and tourniquet.

To reduce the harm to the user and the wider community by providing safe disposal of dirty needles/syringes, which other wise may have been discarded inappropriately in the community.

To provide the community with clean neighborhoods, by going out and picking up dirty discarded needles/syringes.

Objectives:

Build relationships with the individuals so that when they are ready we can do referrals with Addiction Counseling, Methadone Maintenance Clinic, Detoxification and/or Treatment Center's.

Developing a rapport and creating trust and confidentiality with individuals who are at risk for or infected with either or both HIV and Hepatitis "C" these individuals include people who:

- Use or inject drugs
- Sexual partners of individuals who use intravenous drugs
- Sex industry workers
- Homelessness or street involved people.

To minimize the risks associated with illicit substance misuse in our communities.

Staff Education and Training Requirements

Staffing greatly influences the effectiveness of Needle and Syringe Programs. Staff members who are reachable, knowledgeable, experienced with street life, friendly, non-judgmental, non-directive and helpful are likely to be able to develop and sustain rapports with the clients and the community. As well as the personal qualities and skills of the staff, supervision and training are also important.

- First Aid Training and CPR is essential for the NSP staff personnel so that they know what to do or how to handle a situation that requires first aid and cardio-pulmonary resuscitation (CPR).

- Training NSP staff personnel and clients to dispose if used injection equipment safely can reduce the likelihood of injury and transmission of BBV. Clients should be encouraged to educate their peers about the safe disposal of used injection equipment. In the event of a needle stick injury, it is important that staff personnel know the procedures to follow so that the injured person receives timely care.

Post exposure guidelines outline the procedures to follow in the event of a needle stick injury.

Brief post- exposure guidelines include:

- First Aid. Allow wound to bleed freely, cleanse the wound thoroughly with soap and water. If injury or blood contact is with the mucous membranes (i.e. eyes, nose, mouth) flush well with water. Apply a sterile, waterproof bandage.
- Medical attention and Post Exposure Prophylaxis (PEP) (See attached appendix 2) Seek medical attention (within hours) from an emergency department, clinic, or doctor's office. Testing and post exposure prophylaxis may be recommended. Delay or failure to seek medical attention may compromise the effectiveness of treatment.
- Follow-up counseling and Evaluation. Periodic testing for indications of infection as well as counseling for emotional stress may be appropriate. Counseling for prevention of infection transmission is also recommended.
- Documentation & Surveillance. All needle stick injuries should be reported to the manager and documented. This information can be used to develop further strategies to prevent injuries.

(Ontario Needle Exchange Programs: Best Practice Recommendations March 2006).

Safe Injecting Information

There is no completely safe way of injecting drugs. Injecting a drug (rather than smoking, swallowing or sniffing it) carries a greater risk of overdose, vein damage

and infection. However, if an individual chooses to inject there is information that can help reduce the risks of injecting.

- **Femoral (Groin) Injecting** – Injecting in the groin can be extremely dangerous. The vein in your groin is very close to your femoral artery. If you hit the femoral artery you could bleed to death or lose your leg. Injecting in the groin means all veins in your leg suffer a lot of abuse. The vein buried in your groin (the femoral vein) is not like the veins in your arms – if you kill it then your whole leg is in danger.

  The **Femoral Vein** is one of the biggest veins in your body. It returns nearly all of the blood from your leg back to your heart and lungs. Despite the risk of serious health problems some drug users choose to inject into the femoral vein.

  The **Femoral Artery** is one of the biggest arteries in your body. It supplies nearly all the blood to your leg. You need this artery. Without it, your leg would die and drop off – if you hit it by accident you could be in big trouble.

  The **Femoral Nerve** passes messages back and forth between your brain and leg so you can control movement and feel pain and touch. If you hit it with a needle you will be in a lot of pain and could even be paralyzed.

- **Vein Care** – Look after your veins. Veins carry blood back to the heart and lungs at reduced pressure and they need some help. Veins carry blood at a lower pressure and **never** have a pulse – anything with a pulse is an artery. Improving injecting techniques can really reduce vein damage and prevent some serious conditions that affect people with a lot of collapsed veins. It can also prevent or delay the move to riskier sites.

  Why? You have only got one set of veins. If you give them a break when they have been damaged by injecting they can sometimes recover. But once veins collapse they are gone for good. If only a few veins collapsed, the blood can use other veins to get back to the heart, but if more and more veins collapse the arm or (more seriously) leg can become swollen, cold and painful.

  Rotating Sites – Injecting in both arms and varying the places that you inject will give your veins a chance to recover between injections. It is always easier to inject with the hand you write with. Learning to inject with the other hand could help save your veins.

  Avoiding Misses – Injecting some drug into tissues around the vein can be very painful, cause serious infections and drastically shorten the life of veins. Hurrying to get the needle in, not checking its position carefully and pushing the plunger down to quickly can all cause leakage and bleeding around the injection site? If you inject too quickly, the vein may not be able to take the extra fluid, and some can escape into the tissue around the vein.

  When people can't understand how they 'missed' – because they know they were in the vein – it is probably because either the needle has come out of the

vein during the injection, or they have injected too fast and some has leaked out. The smaller the vein, the slower the injection has to be.

Clots and Vein Collapse – Blood is amazing stuff: it flows around our bodies without clotting, but as soon as we get a cut or graze it stops flowing and forms clots, which turns into scabs and then into scar tissue. The lining of veins is perfectly smooth, so that the blood won't clot as it flows along. But the smooth lining of the vein can be damaged by: the needle; the drug (especially tablets); too much acid; injecting too fast or too often; infection; and 'flushing' the syringe after your hit.

When the lining of the vein is damaged clots can form, eventually leading to vein collapse. Veins that are damaged or swollen may partially recover, but collapsed veins never recover. The blood finds another way back to the heart and lungs through smaller or deeper veins further down the system.

New Veins – People sometimes find a new vein, usually near the surface, where there wasn't a visible vein before. Unfortunately these never last because they're not really new veins. What happens is that veins collapse and circulation gets restricted, or gets 're-routed' through smaller and smaller veins. If the pressure in a small vein gets too great, it can blow up like a balloon.

The walls of these veins are very thin and fragile. Sticking a needle in them usually results in a painful bruise. If you are at the stage of finding these 'new veins' you should seriously think about stopping injecting because carrying on is likely to lead to serious, and lifelong, circulation damage.

- **Infections** – Injecting allows bacteria to get past the protective barrier of the skin. When bacteria are injected directly into the bloodstream, the body is usually able to kill them (this is not the case with virus). But when the vein is missed the warm, moist, airless dark space under the skin is an ideal place for them to grow. Infections and swelling around an injection site can slow the flow of blood, and lead to clotting and scarring which can collapse the vein. To prevent infections, abscesses and vein damage it is important to always:

  * use sterile equipment;
  * wash your hands and the injection site with soap and water; and to;
  * clean your mixing equipment before (and ideally after) every injection.

If you do get an infection or swelling in your arm or hand, take off your rings as they can cut off the blood supply. Collapsed veins never recover. Go slow. Be gentle. Rotate sites. Use a new sterile needle every time, **LOOK AFTER YOUR VEINS (Lifeline Publications, Manchester, UK)**

First Aid for Abscesses' and Skin Problems

Best Practice Recommendation – in brief

To prevent Abscesses and skin infections:

- Educate clients about safe injection practices and provide sterile injection equipment and hygiene materials (e.g. alcohol swabs, needles & syringes)
- First Aid as described here is limited to services which can be provided by a non-professional with first aid training; more complex problems require treatment by a physician.

IDMU are at risk for abscesses and skin infections which can harm their health and well-being. NEP/NSP can address prevention of abscesses and skin infections by teaching proper injecting techniques and associated hygiene measures, together with provision of proper sterile injection equipment. In some situations, specific skin infections such as necrotizing fasciitis (a bacterial infection, see appendix 3) can quickly become life-threatening.

Although in general abscesses and other skin infections are not life-threatening, they can be painful and may interfere with the quality of life and result in scarring. This may also lead to more severe conditions such as, septicemia (blood poisoning) if an infection spreads through the blood stream. Many marginalized IDMU do not have a regular source of primary care where such problems can be treated, and will either attend emergency departments for these conditions or will attempt self-treatment.

NEP/NSP is well-placed to address prevention of abscesses and skin infections. These conditions are likely to occur because of inadequate cleaning of the injection site, injection with a needle/syringe with bacterial contamination, and/or injection of non-sterile drugs into a site where they are not readily absorbed or disseminated. If prevention measures fail, or for persons who have not received them, it is important that treatment be provided.

First aid may involve draining abscesses that have formed or providing topical treatment such as ointments for superficial skin infections that have not formed abscesses. In addition, IDMU who are homeless or marginally housed may need first aid treatment for relatively common conditions such as foot problems and skin conditions such as scabies or other infestation. Furthermore, experience and training are necessary to be able to determine under what conditions first aid is insufficient and clients require referral to an emergency department or medical facility. (Ontario Needle Exchange Programs: Best Practice Recommendations March 2006).

Overdose Prevention Education

Best practice recommendations – in brief

To reduce fatal and non-fatal overdose among IDMU

- Educate clients about the risks and signs of overdose
- Educate clients about overdose prevention techniques
- Encourage clients to seek medical assistance in the event of an overdose or distress
- Educate clients about the information to provide when 911 is called
- Provide first aid and cardio-pulmonary resuscitation (CPR) training to clients

Overdose if the leading cause of death among IDMU. Several factors contribute to an increased risk of overdose s, including:

1. Polydrug use (i.e. using different types of drugs and/or alcohol)
2. Loss of drug tolerance (e.g. after incarceration or drug treatment)
3. Hurried injection of drugs
4. injection of drugs from a new or unknown source
5. Unknown strength of drugs
6. Long history of injection drug use
7. Prior nonfatal overdose
8. Injecting alone or having someone else inject the drugs into the user
9. Delay in seeking attention
10. Recent release from prison

However, many overdoses can be prevented with prompt and appropriates medical and other assistance. Overdose deaths seldom occur immediately after injection of drugs evidence suggests that early intervention by emergency personnel greatly increases survival.

Lack of knowledge about overdose

Not all IDMU are knowledgeable about the signs and symptoms of overdose or about the lag time between consumption on onset of overdose symptoms. As a result, symptoms that do not appear immediately after injection may not be interpreted as symptoms of overdose and may not lead IDMU to intervene or seek help. It is important that IDMU seek attention not only in overdose situations but when someone who has injected appears to be in distress.

IDMU often underestimate their personal risk of overdose but are considerably more accurate in estimating other IDMU risk of overdosing. Under estimating personal risk can lead some IDMU to continue with unsafe practices such as injecting alone or injecting larger than usual quantities of drugs.

IDMU commonly have inaccurate knowledge about the techniques likely to be helpful to someone experiencing an overdose. IDMU often believe that to speed recovery, someone experiencing an overdose should be: placed in a cold bath,

injected with more drugs or with salt water, or be inflicted with pain. These commonly held beliefs are inaccurate, could lead to harmful consequences and point to the need for accurate overdose prevention education.

Lack of medical or other assistance

While lack of knowledge about overdose may contribute to overdose-related deaths among IDMU, lack of medical or other assistance during an overdose greatly contributes to deaths. Real or perceived concern about arrest discourages many IDM from seeking assistance for an overdose. Often police are dispatched or their presence is requested by ambulance services when overdose is the reason for calling emergency medical assistance. However, evidence shows that early intervention can reduce the risk of death.

Components of overdose prevention education

Overdose prevention education often includes information and skill building components. In terms of information, education programs include explanations about how to recognize the signs of an overdose and the risks of lower tolerance. The symptoms of overdose vary depending on the drug consumed. For example, opiates may include symptoms such as deep snoring, slow or erratic heartbeat and passing out. A stimulant overdose (e.g. cocaine, methamphetamine) may lead to symptoms such as rapid breathing, high fever, seizure, convulsions, delirium, confusion, sweating, and rapid increase in blood pressure. Overdose education can be provided face-to-face and/or handed out with other program equipment.

First aid training is also included in overdose education programs for IDMU, their family and others who may be present during an overdose. Teaching clients effective resuscitation and basic life support techniques to revive someone who has overdosed can be beneficial until medical help arrives. Teaching clients about the recovery position to prevent users from choking on their own vomit, mouth-to-mouth resuscitation, and cardio-pulmonary resuscitation (CPR) is also recommended.

Since overdose deaths seldom occur immediately after drugs are injected, and there is usually time to intervene, encouraging clients who witness an overdose to seek medical assistance by calling 911 can reduce overdose deaths. However, IDMU may need training about what they need to say when calling 911 for assistance. For example, the literature suggests that when calling 911, IDMU need not mention someone has overdosed but rather inform dispatchers that the person has stopped breathing and provide the address and phone number for the location. However, to provide effective medical assistance when they arrive, paramedics need information about what type of drug consumed and any known medical conditions. As well as encouraging clients to call 911, encouraging them to not leave the person who has overdosed alone is also recommended.

Examples of recommended overdose prevention practices

Recommendations	Rational
Avoid mixing drugs with similar effects	Drugs with similar effects when combined can increase the risk of overdose
When tolerance is low (e.g. after drug treatment or release from jail):	Lowered tolerance can increase the risk of overdose
• Use smaller amount of drugs than before	
• Smoke or snort drugs to reduce the speed of absorption into body	
• Use with someone else present or let someone know to check	
Take care when using drugs from new and/or unknown source:	Using drugs of unknown potency can increase the risk of overdose
• Inject a "test shot" to teat potency	
• Ask others about the potency	
Buy drugs from a regular and trusted source	
Know what to do, and what not to do, if you or someone else shows symptoms of overdose	Early intervention during an overdose can reduce the chances of death
Call for assistance if you or someone else is overdosing	
Do not leave someone who is overdosing alone	Early intervention during an overdose can reduce the chances of death and the chances of victimization

Targeted overdose prevention education

Several factors found to increase the likelihood of death from overdose among the IDMU can be used to identify clients at increased risk and to tailor education programs accordingly. Factors found to increase the risk of death from overdose include: a long history of injecting, high levels of drug use or intoxication, low tolerance, prior non-fatal overdose, homelessness, diagnosis of depression, recent release from jail/prison and a history of using combinations of drugs.

Despite the consequences of overdose for IDMU many fear the consequences of police involvement and delay seeking assistance in overdose situations. In particular, development of partnerships between NSP, the police and emergency personnel can be used to develop and implement procedures that would make IDMU less reluctant to seek medical assistance when necessary. For instance, policies could include ensuring police do not arrest, search or charge IDMU (or others) that have placed an emergency phone call.

As part of safer injection education, attempts have to be made to discourage IDMU from injecting alone. Injecting while someone else is present can increase the chances that if an overdose occurs, someone will call for assistance. However, this type of advice must also reinforce the need to avoid sharing of any injection equipment and to practice safer sex.

Referrals and Counseling

Best Practice Recommendations – in brief

To increase access to community services and other assistance for Injection Drug Mis- Users (IDMU):

- Provide referrals for drug treatment, HIV and HCV counseling and testing, social and mental health services, legal aid and primary healthcare
- Establish and manage referral relationships with agencies providing these services
- Provide clients with information regarding drug treatment, medical care, HIV and HCV counseling and testing and health and social services

Many IDMU do not regularly access health and other social service systems and NEP/NSP are often their only source of assistance with health and social problems. Consequently, NEP/NSP are an important source of referrals for drug treatment and services for the medical, social, emotional and financial needs of IDMU. Some IDMU may not have their services needs met due to lack of knowledge about the community resources available and how to access such services. NEP/NSP staff can play a role to help clients identify their needs and access services.

Since substance use can increase a person's risk of experiencing financial problems or becoming homeless, it is important that IDMU are informed about community services available to address their needs. As well, NEP/NSP can help improve clients awareness of mental health services since IDMU population has shown to experience

high rates of depression and some IDMU participating in NEP/NSP report needing mental health services.

Providing referrals to healthcare and other services is an important role for NEP/NSP. Many NEP/NSP provide referrals to voluntary HIV and HCV counseling and testing, as well as referrals to drug treatment programs. Participation in drug treatment has shown to decrease needle sharing and injection frequency. Referrals clients to drug treatment programs has the potential to reduce or eliminate client drug and risk the risk of acquiring HIV, HCV, HCB and other infections. Research shows that once IDMU become aware of their positive status, HIV and HCV transmission related behaviors tend to decline. (Ontario Needle Exchange Programs: Best Practice Recommendations March 2006).

Appendix 1

Vein Care - Cellulitis,

Skin Infections in IV Drug Mis-users

Best Practice of Medicine - Patient Guide

Press Ctrl-P (PC) or ⌘-P (Mac) to print this page

Patient Guide > Infectious Diseases

Common Skin Infections: Cellulitis, Erysipelas, Impetigo

by Benjamin A. Lipsky, MD, FACP, FIDSA

Visit **http://merck.micromedex.com/index.asp?page=bhg_report&section=report&article_id=BHG01ID08** to view full Report on this topic that includes figures, tables, HEALTH News,HEALTH Alerts, Doctor Visit Checklist, Patients Ask, and Recommended Reading.

Patient Guide Brief

Basics 

- There are three common types of skin infections: cellulitis, erysipelas, and impetigo (pyoderma).

Causes 

- The most common cause of cellulitis is a family of bacteria called Group A streptococcus, the same bacteria that cause strep throat.
- Group A strep usually causes erysipelas. Other streptococcus types and rarely, staphylococcus, another type of bacteria, may be involved.
- A mixture of streptococcus and staphylococcus usually causes impetigo.

Symptoms 

- Both cellulitis and erysipelas start and spread quickly, and cause redness, swelling, pain, and warmth.
- The common form of impetigo begins with a small (2-4 mm/.04-.16 in) reddened, flat area of skin (macule) that rapidly forms either a clear or pus-filled blister (vesicle or pustule). These blisters are fragile and rupture easily, releasing a fluid that dries into a golden crust.
- Skin infections accompanied by cell death (necrotizing infections) often cause pain, fever, malaise, and a dark swelling of the affected area.

Risk Factors 

- Certain conditions that impair circulation or immunity predispose people to skin infections such as cellulitis.
- Skin and soft-tissue infections such as cellulitis are more common among people whose immune systems are not working properly, such as those with cancer.

Diagnosis 

- Your doctor will perform a physical examination of your skin. He or she will suspect cellulitis or erysipelas if you have a spreading, swollen, reddened, warm, and tender area of skin that developed rapidly.
- Your doctor will suspect impetigo if you have a honey-colored crust covering a blistered rash.
- Your doctor may suspect a necrotizing infection if, in addition to skin symptoms similar to those of cellulitis, you have pain that is out of proportion to the apparent size of your infection.

Prevention and Screening 

- It is important to control conditions that might make you more likely to have an outbreak of cellulitis.

Urgent Care 

- Emergency hospitalization is not normally needed in cases of uncomplicated cellulitis, erysipelas, or impetigo.
- If you have a severe case of cellulitis or erysipelas, you may need to go to the hospital for intravenous medication.
- Flesh-eating bacterial infections (necrotizing soft-tissue infections) are a life-threatening complication of untreated cellulitis, and require immediate hospitalization.

Self Care 

- Keep skin infections, cuts, and abrasions clean with soap and water.
- If possible, keep the affected area elevated, and avoid putting weight on it. This will help to reduce swelling, and will protect the skin from further infection.
- If you have leg or arm swelling (edema) that results from surgery or problems with blood flow, your doctor may ask you to wear elastic compression sleeves or stockings to reduce the swelling.
- Treat dry skin, fungal infections (i.e., athlete's foot), and other skin disorders so they do not turn into cellulitis.
- Shower or bathe regularly, and see your doctor immediately to report any ongoing or unusual reddening of the skin. This is particularly important if symptoms such as swelling or fever occur.
- Maintain a healthy weight, as obesity can contribute to cellulitis and impetigo.
- If you have cellulitis or erysipelas, report any worsening of symptoms to your doctor right away.

Drug Therapy 

- Your doctor is the best source of information on the drug treatment choices available to you.

Other Therapies 

- Hyperbaric oxygen therapy is thought by some physicians to benefit people with necrotizing infections. It is not, however, widely available.

Surgery

- Uncomplicated cellulitis, erysipelas, and impetigo do not normally require surgery.
- In cases where necrotizing infections are suspected, surgical exploration and cleaning out the wound (debridement) may be necessary.

Alternative Medicine 

- There are no alternative treatments shown to be safe or effective for cellulitis, impetigo, and ersipelas. Moisturizing creams or aloe vera may help treat certain predisposing skin conditions.

Special Circumstances 

- If you have a condition such as diabetes or HIV, you should be very alert to any changes in your skin that may suggest cellulitis or erysipelas. This holds true for those who have had repeated episodes of cellulitis as well.

Prognosis 

- Cellulitis, erysipelas, and impetigo, when seen promptly by a physician, normally can be treated with little difficulty.
- The redness and inflammation of cellulitis and impetigo may be a little worse the day after treatment is started.
- Necrotizing infections are serious, and can cause death if they are not treated quickly.

Follow-up 

- Your doctor will treat your case in an individual manner based on the extent of the infection.
- Be sure to contact your doctor if your condition does not get better, or worsens.
- If you have problems taking a prescribed medication, let your doctor know.

Appendix 2

Post Exposure Prophylaxis

Post Exposure Prophylaxis

What it is

Post Exposure Prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

Why it is Important

The risk of transmission of HIV from an infected patient through a needlestick where the skin is punctured by a sharp is less than 1%. The risk for transmission from exposure to infected fluids or tissues is believed to be lower than for exposure to infected blood.

The risk of exposure from needlesticks and other means exists in many settings where protective supplies are limited and the rates of HIV infection in the patient population are high. The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in health care workers. It is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace.

There is significant debate on the need to use PEP after sexual exposure. The UN offers PEP to its staff in cases of rape when the likelihood of HIV exposure is considered high.

How it is done

The proper use of supplies, staff education and supervision needs should be outlined clearly in institutional policies and guidelines.

Regular supervision in health care settings can help to deter or reduce risk of occupational hazards in the workplace. If injury or contamination result in exposure to HIV infected material, post exposure counselling, treatment, follow-up and care should be provided. Post exposure prophylaxis (PEP) with antiretroviral treatment may reduce the risk of becoming infected.

Prevention of Exposure

Prevention of exposure remains the most effective measure to reduce the risk of HIV transmission to health workers. The priority must be to train health workers in prevention methods (universal precautions) and to provide them with the necessary materials and protective equipment. Staff should as

well be knowledgeable about risks of acquiring HIV sexually, and be easily able to access condoms and confidential STI treatment services.

Managing Occupational Exposure to HIV

- First AID should be given immediately after the injury: wounds and skin sites exposed to blood or body fluids should be washed with soap and water, and mucous membranes flushed with water.
- The exposure should be evaluated for potential to transmit HIV infection (based on body substance and severity of exposure).
- PEP for HIV should be provided when exposure to a source person with HIV has occurred (or the liklihood that the source person is infected with HIV).
- The exposure source should be evaluated for HIV infection. Testing of source persons should only occur after obtaining informed consent, and should include appropriate counselling and care referral. Confidentiality must be maintained.
- Clinical evaluation and baseline testing of the exposed health care worker should proceed only after informed consent.
- Exposure risk reduction education should occur with counsellors reviewing the sequence of events that preceded the exposure in a sensitive and non-judgmental way.
- An exposure report should be made.

Appendix 3

Necrotizing Fasciitis

NECROTIZING FASCIITIS
Commonly Known as The "Flesh Eating" Bacteria
Common Questions Answered as Simply as Possible
Published by the National Necrotizing Fasciitis Foundation

How do you say It?

The pronunciation is *neck-row-tize-ing fash-e-i-tis*, it means decaying infection of the fascia.

What Is It?

It is a bacterial infection caused commonly by group A Strep bacteria, which is the same bacteria that causes common Strep throat. Usually easily killed by antibiotics, sometimes a very strong variety of Strep occurs. This is the one that causes the life-threatening cases and is known as the "flesh-eating" bacteria. NF can also be caused by other bacteria, or a mixture of bacteria. The bacteria destroys soft tissue at the subcutaneous level, and often is coupled with toxic shock syndrome, both are deadly alone, together they are even more so. If muscle is destroyed, it is necrotizing myositis.

How do you get it?

Most often the bacteria enter the body through an opening in the skin, quite often a very minor opening, even as small as a paper cut, a staple puncture, or a pin prick. It can also enter through weakened skin, like a bruise, blister, or abrasion. It can also happen following a major trauma or surgery, and in some cases there appears to be no identifiable point of entry.

Where does the bacteria come from?

It is most commonly transferred by respiratory droplets or direct contact with secretions of someone carrying Strep A. For instance, a person carrying a Strep A bacteria might not even show symptoms or become ill at all. They cough or sneeze, another person picks up the bacteria on their hands or directly at the point of a wound and the infection occurs. The NF patient is not likely to be contagious, and inanimate objects are unlikely to be points of transmission.

How can it be prevented?

It can't necessarily be prevented, but you can lessen your chances with some basic hygienic practices. Buy anti-bacterial soap and use it! From the offensive standpoint, cover your mouth when you cough or sneeze, throw away tissues, wash hands frequently. You could be the carrier and not know it. Fifteen to thirty per cent of the population carries Strep A at any given time usually with no

symptoms. From a defensive standpoint: wash hands frequently, avoid contact with persons showing sore throat symptoms. Clean and care for even the smallest traumas, using an antibiotic ointment and sterile covering with frequent changes. Click for more info on preventing Necrotizing Fasciitis.

What are the symptoms?

The symptoms are varied, but often include:

EARLY SYMPTOMS (usually within 24 hours) :

1. Usually a minor trauma or other skin opening has occurred (the wound does not necessarily appear infected)
2. Some pain in the general area of the injury is present. Not necessarily at the site of the injury but in the same region or limb of the body
3. The pain is usually disproportionate to the injury and may start as something akin to a muscle pull, but becomes more and more painful
4. Flu like symptoms begin to occur, such as diarrhea, nausea, fever, confusion, dizziness, weakness, and general malaise
5. Intense thirst occurs as the body becomes dehydrated
6. The biggest symptom is all of these symptoms combined. In general you will probably feel worse than you've ever felt and not understand why.

ADVANCED SYMPTOMS (usually within 3-4 days):

1. The limb, or area of body experiencing pain begins to swell, and may show a purplish rash
2. The limb may begin to have large, dark marks, that will become blisters filled with blackish fluid
3. The wound may actually begin to appear necrotic with a bluish, white, or dark, mottled, flaky appearance

CRITICAL SYMPTOMS (usually within 4-5 days):

1. Blood pressure will drop severely
2. the body begins to go into toxic shock from the toxins the bacteria are giving off
3. unconsciousness will occur as the body becomes too weak to fight off this infection.

When should I seek medical attention?

Any time all of the early symptoms are present, go to a doctor at once, and insist that this be ruled out. The vast majority of cases are misdiagnosed. People have been told that they had fallen, when they didn't, they have had casts put on bones that were not broken, have been given Tylenol for flu and been told to come back the next day; they have been told they have an ingrown toenail, they've been told they have arthritis; they've been accused of burning themselves...many of these people have gone back to the hospital two days later and died. Insist that this be ruled out if you have all of the early symptoms.

Why are so many cases of NF misdiagnosed?

Because the beginning symptoms look like so many other minor afflictions. None of the symptoms are exclusive to this, and until the patient is so ill that they are critical many health care workers don't consider NF. Although the disease is on the increase worldwide, it is still considered uncommon, so many emergency rooms may never have seen a case before.

How rare is NF?

The statistics vary, and are not entirely accurate. A 1996 CDC report estimates from 500 to 1500 cases per year of necrotizing fasciitis of which 20% die. In 1998 the NNFF estimates the figure to be higher (based on cases reported to us measured against the general population with access to the Internet, which is how all of the cases we get are reported)

How is NF treated?

NF must be treated in the hospital with antibiotic IV therapy and aggressive debridement (removal) of affected tissue. Other treatments will take place depending upon the level of toxicity or organ failure being experienced by the patient. Medications to raise blood pressure, blood, and a new medicine called *intravenous immunoglobulin (IVIG)* are also used. A hyperbaric oxygen chamber is sometimes used in certain cases involving a mixed bacterial infection.

What's the likely outcome?

Anywhere from minimal scars to death and everywhere in between. For those lucky enough to survive most often at least some removal of skin is required. Often this requires skin grafting. Amputation is sometimes needed to remove the affected limb. Legs, hands, fingers, toes, arms, have all been sacrificed to save the life of NF patients.

Appendix 4

Drug Information

Drug Definition and Other Drug-Related Information

Heroin – an alkaloid, prepared from morphine be acetylation, rapidly metabolized to morphine in the body.

Morphine – an opiate – it produces a combination of depression and excitement in the central nervous system, predominance of either central stimulation or depression depends upon the species and dose. (named after Morpheus – God of Dreams or Sleep).

Cocaine – crystalline alkaloid obtained from leaves of the coca plant. A potent central nervous system, stimulant, widely abused as a euphoriant and associated with the risk of severe adverse physical and mental effects.

Methadone - is a synthetic diphenylheptane – derivative opioid agonist with pharmalogical properties qualitatively similar to those of morphine. Methadone can produce a similar or slightly higher degree of respiratory depression and less sedation, euphoria and constipation than morphine. Methadone prevents withdrawal symptoms and reduces opioid cravings in individuals who are opioid dependent. Methadone is used in detoxification or maintenance treatment of opioid-dependent individuals and an analgesic in acute and chronic pain disorders.

Talwin – (pentazocine, narcotic analgesic) it produces both analgesic (agonist) and narcotic antagonist effects, overdose similar to that of morphine or other opioids. This may include somnolence, respiratory depression, hypo/hypertension, hallucinations and seizures. Naloxone is a specific and effective antagonist.

Ritalin - Stimulant – used to treat Attention Deficit Hyperactive Disorder (ADHD). A combination of Talwin and Ritalin produces a heroin like high – known as poor mans heroin - commonly used by the IDMU population.

Overdose – Opioids - respiratory depression, extreme somnolence progressing to stupor or coma, cold or clammy skin, skeletal muscle flaccidity, and severe overdose may result in apnea, circulatory collapse, cardiac arrest and death.

Overdose – Stimulant – Ritalin overdose - vomiting, agitation, tremors, muscle, twitching, convulsions (may follow coma) sweating, palpitations, confusion, hallucinations, flushing, headache, in presence of severe intoxication, use a carefully titrated dosage of short acting barbiturate before performing gastric lavage.

Naloxone - a pure opioid antagonist is used as a specific antidote to reverse the effects of opioid agonist and antagonist.

Agonist – a drug capable of combining with receptors to initiate drug reactions.

Antagonist – something opposing or resisting the action of another opioid – agents such as Naloxone and Naltrexone that have affinity for opioid receptors. These drugs block the effects of exogenously administered opioids such as morphine, herion, meperidine and methadone.

Appendix 5

APSS Needle & Syringe Program and Related Policies and Procedures

apss aids programs south saskatchewan	**DIVISION:** Needle Syringe Program			**POLICY NO:NSP 1**
	ISSUED: December 06	**REVISED:**	**PAGE: 1**	**OF:**
	TOPIC: Provide sterile needles/syringes			

Preamble

To prevent the transmission of HIV, HBV, HCV and other blood borne viruses from injection with non-sterile needles/syringes:

Procedure

- Provide sterile needles/syringes in the quantities requested by client:

    1. without requiring clients to return used needles/syringes
    2. with no limit on the number of needles provided with the encouragement to return used needles/syringes
    3. once a staff member becomes familiar with the clients, upon discretion of who returns the needles/syringes when they say they will or those who don't return used ones?

- Provide sharp containers and alcohol swabs to the clients and other available paraphernalia
- Do not penalize clients who fail to return used needles/syringes

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 2
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 2
	TOPIC: **Safer handling and disposal of used injection equipment**			

Preamble

To prevent the transmission of HIV, HBV, HCV and other blood borne viruses (BBV), as well as bacterial infections from improperly discarded injection equipment. The safe disposal of used needles (sharps) is an important strategy to reduce the amount of discarded needles in the community and the transmission of blood borne viruses BBV among IDMU, NSP staff personnel and the community. Removing the used needles from circulation helps reduce the risk of accidental needle stick injuries and the likelihood that the needles will be reused.

Procedure

1. Educate staff and clients to safely handle and dispose of used injection equipment
2. Do not penalize clients who fall to return used needles
3. Estimate the number of needles returned by clients. Neither staff or clients should count used needles by hand
4. Dispose of used needles and sharps container's in accordance with local regulations for biomedical waste
5. Encourage HBV vaccination for staff and clients

Handling used injection equipment: Recommendations for clients

1. Locate the sharps container close to area of use
2. Dispose of injection equipment immediately
3. Never re-cap a needle. This may lead to a needle stick injury, and (re)infection of HIV, HBC,HCV and other BBV
4. When exchanging needles for other people, ask them to deposit them in a sharps container first
5. Do not bend or break a needle

Handling used injection equipment: Recommendations for NSP Staff Personnel

1. Be aware that clients exchanging needles may be carrying needles on their person (e.g. in pockets, sleeves) or loose in a non-secure containers such as plastic or paper bags.
2. do not touch returned needles, clients must dispose their own needles, if a number of needles returned is required this can be done by eyeballing and/or asking clients how many needles they are returning.
3. When collecting used injection equipment discarded in the community always wear puncture resistant gloves or use the tong provided for needle pick-up.

apss aids programs south saskatchewan	**DIVISION:** Needle Syringe Program			**POLICY NO:NSP 3**
	ISSUED: December 06	**REVISED:**	**PAGE: 1**	**OF: 1**
	TOPIC: Post exposure guidelines			

Preamble

Post exposure guidelines outline the procedures to follow in the event of a needle stick injury.

Procedure

Brief post- exposure guidelines include:

- First Aid. Allow wound to bleed freely, cleanse the wound thoroughly with soap and water. If injury or blood contact is with the mucous membranes (i.e. eyes, nose, mouth) flush well with water. Apply a sterile, waterproof bandage.
- Medical attention and Post Exposure Prophylaxis (PEP) (See attached appendix 2) Seek medical attention (within hours) from an emergency department, clinic, or doctor's office. Testing and post exposure prophylaxis may be recommended. Delay or failure to seek medical attention may compromise the effectiveness of treatment.
- Follow-up counseling and Evaluation. Periodic testing for indications of infection as well as counseling for emotional stress may be appropriate. Counseling for prevention of infection transmission is also recommended.
- Documentation & Surveillance. All needle stick injuries should be reported to the manager and documented. This information can be used to develop further strategies to prevent injuries.

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 4
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 1
	TOPIC: **Safe Injecting Information/femoral**			

Preamble

There is no completely safe way of injecting drugs. Injecting a drug (rather than smoking, swallowing or sniffing it) carries a greater risk of overdose, vein damage and infection. However, if an individual chooses to inject there is information that can help reduce the risks of injecting.

Policy

The injecting into a femoral vein will be completely discouraged by this program.

Procedure

- **Femoral (Groin) Injecting** – Injecting in the groin can be extremely dangerous. The vein in your groin is very close to your femoral artery. If you hit the femoral artery you could bleed to death or lose your leg. Injecting in the groin means all veins in your leg suffer a lot of abuse. The vein buried in your groin (the femoral vein) is not like the veins in your arms – if you kill it then your whole leg is in danger.

  The **Femoral Vein** is one of the biggest veins in your body. It returns nearly all of the blood from your leg back to your heart and lungs. Despite the risk of serious health problems some drug users choose to inject into the femoral vein.

  The **Femoral Artery** is one of the biggest arteries in your body. It supplies nearly all the blood to your leg. You need this artery. Without it, your leg would die and drop off – if you hit it by accident you could be in big trouble.

  The **Femoral Nerve** passes messages back and forth between your brain and leg so you can control movement and feel pain and touch. If you hit it with a needle you will be in a lot of pain and could even be paralyzed.

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 5
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 2
	TOPIC: **Safe Injecting Information/vein maintenance**			

Preamble

Users have only got one set of veins. If veins are given a break when they have been damaged by injecting they can sometimes recover. But once veins collapse they are gone for good. If only a few veins collapsed, the blood can use other veins to get back to the heart, but if more and more veins collapse the arm or (more seriously) leg can become swollen, cold and painful.

Procedure

Inform clients when possible about the following information

- **Vein Care** – Look after your veins. Veins carry blood back to the heart and lungs at reduced pressure and they need some help. Veins carry blood at a lower pressure and **never** have a pulse – anything with a pulse is an artery. Improving injecting techniques can really reduce vein damage and prevent some serious conditions that affect people with a lot of collapsed veins. It can also prevent or delay the move to riskier sites.

  Rotating Sites – Injecting in both arms and varying the places that you inject will give your veins a chance to recover between injections. It is always easier to inject with the hand you write with. Learning to inject with the other hand could help save your veins.

  Avoiding Misses – Injecting some drug into tissues around the vein can be very painful, cause serious infections and drastically shorten the life of veins. Hurrying to get the needle in, not checking its position carefully and pushing the plunger down to quickly can all cause leakage and bleeding around the injection site? If you inject too quickly, the vein may not be able to take the extra fluid, and some can escape into the tissue around the vein.

When people can't understand how they 'missed' – because they know they were in the vein – it is probably because either the needle has come out of the vein during the injection, or they have injected too fast and some has leaked out. The smaller the vein, the slower the injection has to be.

Clots and Vein Collapse – Blood is amazing stuff: it flows around our bodies without clotting, but as soon as we get a cut or graze it stops flowing and forms clots, which turns into scabs and then into scar tissue. The lining of veins is perfectly smooth, so that the blood won't clot as it flows along. But the smooth lining of the vein can be damaged by: the needle; the drug (especially tablets); too much acid; injecting too fast or too often; infection; and 'flushing' the syringe after your hit.

When the lining of the vein is damaged clots can form, eventually leading to vein collapse. Veins that are damaged or swollen may partially recover, but collapsed veins never recover. The blood finds another way back to the heart and lungs through smaller or deeper veins further down the system.

New Veins – People sometimes find a new vein, usually near the surface, where there wasn't a visible vein before. Unfortunately these never last because they're not really new veins. What happens is that veins collapse and circulation gets restricted, or gets're-routed' through smaller and smaller veins. If the pressure in a small vein gets too great, it can blow up like a balloon.

The walls of these veins are very thin and fragile. Sticking a needle in them usually results in a painful bruise. If you are at the stage of finding these 'new veins' you should seriously think about stopping injecting because carrying on is likely to lead to serious, and lifelong, circulation damage.

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 6
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 1
	TOPIC: **Safe Injecting Information/infection**			

Preamble

- **Infections** – Injecting allows bacteria to get past the protective barrier of the skin. When bacteria are injected directly into the bloodstream, the body is usually able to kill them (this is not the case with virus). But when the vein is missed the warm, moist, airless dark space under the skin is an ideal place for them to grow. Infections and swelling around an injection site can slow the flow of blood, and lead to clotting and scarring which can collapse the vein. To prevent infections, abscesses and vein damage it is important to always:

Policy

Inform NSP users whenever possible to:

Procedure

* use sterile equipment;
* wash your hands and the injection site with soap and water; and to;
* clean your mixing equipment before (and ideally after) every injection.

If you do get an infection or swelling in your arm or hand, take off your rings as they can cut off the blood supply. Collapsed veins never recover. Go slow. Be gentle. Rotate sites. Use a new sterile needle every time.

To prevent Abscesses and skin infections:

- Educate clients about safe injection practices and provide sterile injection equipment and hygiene materials (e.g. alcohol swabs, needles & syringes)
- First Aid as described here is limited to services which can be provided by a non-professional with first aid training; more complex problems require treatment by a physician.

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 7
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 1
	TOPIC: First Aid for Abscesses' and Skin Problems			

First aid may involve draining abscesses that have formed or providing topical treatment such as ointments for superficial skin infections that have not formed abscesses. In addition, IDMU who are homeless or marginally housed may need first aid treatment for relatively common conditions such as foot problems and skin conditions such as scabies or other infestation. Furthermore, experience and training are necessary to be able to determine under what conditions first aid is insufficient and clients require referral to an emergency department or medical facility. (Ontario Needle Exchange Programs: Best Practice Recommendations March 2006).

Policy

Wherever possible staff should take first aid training and will be encouraged to do so.

Wound cleaning supplies are available for clients use. Peroxide and bandaids.

apss aids programs south saskatchewan	DIVISION: Needle Syringe Program			POLICY NO:NSP 8
	ISSUED: December 06	REVISED:	PAGE: 1	OF: 1
	TOPIC: **Overdose Prevention Education**			

Preamble

Many overdoses can be prevented with prompt and appropriates medical and other assistance. Overdose deaths seldom occur immediately after injection of drugs evidence suggests that early intervention by emergency personnel greatly increases survival.

Policy

To reduce fatal and non-fatal overdose among IDMU

- Educate clients about the risks and signs of overdose
- Educate clients about overdose prevention techniques
- Encourage clients to seek medical assistance in the event of an overdose or distress
- Educate clients about the information to provide when 911 is called
- Provide first aid and cardio-pulmonary resuscitation (CPR) training to clients

Overdose if the leading cause of death among IDMU. Several factors contribute to an increased risk of overdose s, including:

1. Polydrug use (i.e. using different types of drugs and/or alcohol)
2. Loss of drug tolerance (e.g. after incarceration or drug treatment)
3. Hurried injection of drugs
4. injection of drugs from a new or unknown source
5. Unknown strength of drugs
6. Long history of injection drug use
7. Prior nonfatal overdose
8. Injecting alone or having someone else inject the drugs into the user
9. Delay in seeking attention
10. Recent release from prison

apss *aids programs south saskatchewan*	**DIVISION:** Needle Syringe Program			**POLICY NO:NSP 9**
	ISSUED: December 06	**REVISED:**	**PAGE: 1**	**OF: 1**
	TOPIC: Referrals and Counseling			

Preamble

To increase access to community services and other assistance for Injection Drug Mis-Users (IDMU):

Policy

- Provide referrals for drug treatment, HIV and HCV counseling and testing, social and mental health services, legal aid and primary healthcare
- Establish and manage referral relationships with agencies providing these services
- Provide clients with information regarding drug treatment, medical care, HIV and HCV counseling and testing and health and social services

	DIVISION: Personnel			POLICY NO. 2 – P38
	ISSUED: Sept 21, 1999	REVISED November, 2005	PAGE: 1	OF: 2
	TOPIC: Safety & Critical Situations – Workplace Conduct			

Purpose: To ensure that procedures are in place to protect employees and to ensure employees respond consistently to critical situations within the organization.

Policy: APSS is committed to the prevention or minimization of violence and aggression in the workplace as well as providing employees with responses to critical situations they may witness in this work environment.

The safety of employees, volunteers and anyone accessing our facility is a priority within the organization. **APSS is NOT a critical crisis intervention agency.**

Definitions: Violence is defined in section 37 (1) of the Occupational Health & Safety Regulations ".....violence means the attempt, threatened or actual conduct of a person that causes or is likely to cause injury, and includes any threatening statement or behaviour that gives a worker reasonable cause to believe that the worker is at risk of injury".

Critical incident is any situation where there has been a violent encounter, there is likely to be violence due to a situation, including domestic situations, someone is reporting assault or other act of aggression.

Some examples may be:

- Assault, including actual bodily harm
- Pushing, shoving
- Verbal threats
- Yelling, swearing
- Gestures resulting in humiliation or ridicule
- Clients or public exhibiting any of the above (domestic disputes, which are extremely volatile and where 3rd parties are most likely to be injured).

Scope: This policy applies to all individuals connected toor carrying out the business of this organization.

Procedure:

- Be knowledgeable of your physical area, safe place, phones, and barriers to escape.
- Assess your immediate situation. Ask anyone displaying aggression to leave the premises (do this in a calm but firm voice).
- If the person does not comply inform them you will call the police, if there is still non-compliance, call 911.

- If someone enters the premises reporting they have been injured or in some other aggressive altercation, inform them you MUST call 911. If they do not want you to do this tell them they have to go somewhere else for assistance (do this in a calm, compassionate but firm voice).
- If the individual stays two (2) permanent staff MUST monitor the individual and remain until the situation is resolved. Calling an ambulance if necessary. IF someone has a head injury ALWAYS call an ambulance, informing the person that you are going to do so.
- Report ANY instances IMMEDIATELY to Management. DO NOT start to deal with situations alone or without reporting to another staff in the absence of management.
- ALL incidences MUST be written up within 24 hours of the occurrence. This may be needed for legal purposes and for evaluation of our handling of a situation. Include:

    - Nature of incident
    - Sequence of events, persons involved and their roles.
    - What measures were taken.
    - What was the resolution to the situation.

A debriefing meeting will be called as soon after the incident as is possible.

Each agency in the premises MUST report any situation that has or may lead to repercussions to each other.

NEVER disclose a persons HIV or any other health information to police, health professionals or any other service provider outside of this organization as a result of these types of altercations OR for any other reason what so ever.

It is recommended that any employee or volunteer exposed to these situations debrief with others in the organization, consult with their physician or seek post-stress counseling. The employee will NOT lose time due to post-stress care.

apss *aids programs south saskatchewan*	**DIVISION:** Needle Syringe Program			**POLICY NO:NSP 1**
	ISSUED: December 06	**REVISED:**	**PAGE: 1**	**OF:**
	TOPIC: Protect Employees from Hepatitis A& B			

Preamble

To protect employees from the risk transmission of Hepatitis A and B through the course of their duties:

Procedure

Employees working in the Needle Syringe Distribution program will undertake a course of Hepatitis A & B (Twinrix) vaccinations.

	DIVISION: Client Services Living Positive Ribbons of Hope Needle Distribution			**POLICY NO: 6-P19**
	ISSUED: April 1997	**REVISED: October, 1999**	**PAGE: 1**	**OF: 1**
	TOPIC: Discontinuance of Client Service			

Purpose: To outline the procedure that APSS uses to discontinue support services to a client.

Policy: APSS will discontinue client services to any client who:

1. provide fraudulent information to obtain financial assistance grants
2. does not use financial grants for the purposes issued
3. fails to provide receipts for financial grant purchases
4. consistent abusive or threatening behaviour to employee or volunteers
5. consistent out of control behaviour associated with the abuse of alcohol, non prescription drugs or prescription medication
6. steals from the agency

Failure to demonstrate respectful behaviours may prompt a review of service provision.

Procedure: No services to a client will be discontinued without a consultation between the Client Services Staff or Executive Director.

Reason for discontinuing a service to a client must be clearly documented by the Client Services Staff.

The consultation will endeavour to reach alternative solutions if possible.

Any client who has service discontinued (or altered) must be informed of the consultation decision by the Client Services Staff.

The Client Services Staff must inform a client both verbally and in a form letter of service discontinuance (or alteration).

The client will have an opportunity to appeal the decision. This appeal should be forwarded to the Executive Director.

	DIVISION: Client Services **Living Positive** **Ribbons of Hope** **Needle Distribution**			**POLICY NO: 6-P18**
	ISSUED: April 1997	**REVISED: October, 1999**	**PAGE: 1**	**OF: 1**
	TOPIC: Right to Refuse Client Services			

Purpose: To outline specific situations that refuse for APSS to refuse provision of support services to a client.

Policy: APSS will refuse services to any client who:

1. fails to provide proof of HIV+ status (Positive Living)
2. provides fraudulent information
3. demonstrates abusive or threatening behaviour
4. is currently under the influence of non-prescription drugs or alcohol to a degree that they are impaired and out of control

Procedure: All clients who have services refused, will be informed of the reason by the Client Services Staff.

	DIVISION: Client Services Living Positive Ribbons of Hope **Needle Distribution**			**POLICY NO: 6-P8**
	ISSUED: April 1997	**REVISED: October, 1999**	**PAGE: 1**	**OF: 1**
	TOPIC: Counselling of Safe Behaviour Guidelines to Clients			

Purpose: To state APSS policy regarding safe behaviour and personnel responsibility.

Policy: All clients of APSS shall be counselled that APSS strongly advises the practice of safer sexual behaviour, the safe cleaning and usage of intravenous equipment and the informed consent of sexual partners.